Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Sam Houston State University

Policy Year: 2025 – 2026
Policy Number: 175364
www.aetnastudenthealth.com
(888) 407-0445

Disclosure: These rates and benefits are pending approval by the Texas Department of Insurance and can change. If they change, we will update this information.

Important note:

You have the right to an adequate network of preferred providers (known as "network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

You have the right, in most cases, to obtain estimates in advance from out-of-network providers of what they will charge for their services and from your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.aetna.com or by calling Aetna Member Services at the toll-free number on your ID card for assistance in finding available preferred providers.

If you are treated by a provider or facility that is not a preferred provider, you may be billed for anything not paid by the insurer unless balance billing is prohibited.

If directory information is materially inaccurate and you rely on it, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

This is a brief description of the Student Health Plan. The plan is available for Sam Houston State University students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Sam Houston State University
Student Health Center
1608 Avenue J
Huntsville, TX 77340

Medical Clinic
8am to 5pm, Mon-Fri

Laboratory
8am to 5pm, Mon-Fri

STUDENT HEALTH CENTER: The deductible will be waived, and covered expenses paid at 100% based upon Aetna allowable.

For more information, call the Health Services at **(936) 294-1805** , In the event of an emergency, call 911 or the Campus Police at **(936) 294-1000**

Student Coverage
Who is eligible?

Domestic & Distance Learning Students

All registered **Domestic Undergraduate Students** taking nine (9) or more credit hours (three (3) or more credit hours during summer sessions) to be eligible to participate in the plan on a voluntary basis.

All registered **Domestic Graduate Students** taking six (6) or more credit hours (three (3) or more credit hours during summer sessions) to be eligible to participate in the plan on a voluntary basis.

Distance Learning Students taking nine (9) or more credit hours and paying the SHSU Medical Services Fee are eligible to participate in the plan on a voluntary basis.

Voluntary coverage will only be sold by fall, spring/summer and summer semester, and student must meet eligibility requirements each semester. Dependent coverage is not offered for Domestic or Distance Learning Students.

International Students

All enrolled International Students in the United States with nonimmigrant F-1 and J-1 student visa classifications are subject to the mandatory health insurance requirement. Students can either enroll in the health insurance plan or submit a waiver with equivalent insurance coverage that is government-sponsored or U.S. employer-sponsored. Dependents of nonimmigrant F-1 and J-1 students may be enrolled as a dependent of the Sam Houston State University primary visa student (F-1 or J-1). Students on other visa types are eligible to enroll as a voluntary student.

College of Osteopathic Students

All registered College of Osteopathic Medicine Students are automatically enrolled in the plan unless proof of comparable coverage is provided.

Visit the website **shsu.myahpcare.com** to enroll / renew your coverage online. For additional information, contact Student Health Services at (936) 294-1805.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV).

Dependent Coverage Eligibility

Dependent coverage is not offered for **Domestic or Distance Learning Students**

Eligible dependents of **International Students** may participate in the plan on a voluntary basis. Payment must be paid directly to Academic HealthPlans and may not be billed to the student's account. Dependents will NOT automatically be re-enrolled. You will need to re-enroll them by each semester's deadline.

Dependent coverage is available for **College of Osteopathic Medicine Students**. Payment must be paid directly to Academic HealthPlans and may not be billed to the student's account. Dependents will NOT automatically be re-enrolled. You will need to re-enroll them by each semester's deadline.

Coverage for all insured students and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Dates

Domestic & Distance Learning Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall	08/01/2025	12/31/2025	09/13/2025
Spring/Summer	01/01/2026	07/31/2026	01/30/2026
Summer	05/08/2026	07/31/2026	06/11/2026

Rates
Domestic & Distance Learning Students

	Fall	Spring/Summer	Summer
Student Only	$2,038.00	$2,820.00	$1,131.00

Coverage Dates
International Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall	08/01/2025	12/31/2025	09/13/2025
Spring/Summer	01/01/2026	07/31/2026	01/30/2026

Rates
International Students

	Fall	Spring/Summer
Student	$979.00	$1,354.00
Spouse	$979.00	$1,354.00
Child	$979.00	$1,354.00
Child, Two or More	$1,958.00	$2,708.00

Coverage Dates
College of Osteopathic Medicine

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall	08/01/2025	12/31/2025	08/01/2025
Spring/Summer	01/01/2026	07/31/2026	02/01/2026

Rates
College of Osteopathic Medicine

	Fall	Spring/Summer
Student	$979.00	$1,354.00
Spouse	$979.00	$1,354.00
Child	$979.00	$1,354.00
Child, Two or More	$1,958.00	$2,708.00

The rates above reflect premiums for the student health insurance plan, inclusive of administrative fees. This is prorated for other periods of enrollment.

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to:

Domestic and Distance Learning Students - https://shsu-dom.myahpcare.com/

International Students - https://shsu-intl.myahpcare.com/

College of Osteopathic Medicine Students - https://shsu-com.myahpcare.com/

Important note regarding coverage for a newborn child or adopted child:

Newborn child

- Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
- To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31-day period.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- If your coverage ends during this 31-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

Adopted child or a child legally placed with you for adoption

A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after you become party in a suit to adopt the child or the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption, after you become party in a suit to adopt the child, or after placement for adoption.
- You must still enroll the child within 31 days of the adoption, you become party in a suit to adopt the child or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
- If you miss this deadline, your adopted child, the child for whom you became a party in a suit to adopt, or the child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31-day period, then coverage for your adopted child the child for whom you became a party in a suit to adopt, or the child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

Dependent coverage due to a court orde

If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
- You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
- If you miss this deadline, your dependent will not have health benefits after the first 31 days.
- If your coverage ends during this 31-day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have questions on dependent enrollment, call Member Services at 888-407-0445.

Termination and Refunds

Withdrawal from Classes – Leave of Absence: If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence: If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

Coordination of Benefits (COB)

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID card. A complete description of the Coordination of Benefits provision is contained in the Policy issued to Sam Houston State University and may be viewed online at **www.aetnastudenthealth.com**.

In-network Provider Network

Aetna Student Health offers Aetna's broad network of In-network Providers. You can save money by seeing In-network Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better.

If you need care that is covered under the Plan but not available from an In-network Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for In-network Providers.

Preauthorization

You need pre-approval from us for some eligible health services. Pre-approval is also called preauthorization. Your in-network physician is responsible for obtaining any necessary preauthorization before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain preauthorization from us for any services and supplies on the preauthorization list. If you do not preauthorize when required, there is a **$500** penalty for each type of eligible health service that was not preauthorized. For a current listing of the health services or prescription drugs that require preauthorization, contact Member Services or go to **www.aetnastudenthealth.com**.

Preauthorization call

Preauthorization should be secured within the timeframes specified below. To obtain preauthorization, call Member Services at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

Non-emergency admissions	Call at least 3 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 3 days before the care is provided, or the treatment is scheduled.

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.

We will provide a written notification to you and your physician of the preauthorization decision, where required by state law. If your preauthorized services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to **www.aetnastudenthealth.com**.

This Plan will pay benefits in accordance with any applicable **Texas** Insurance Law(s).

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$500 per policy year	$1,000 per policy year
Spouse	$500 per policy year	$1,000 per policy year
Each Child	$500 per policy year	$1,000 per policy year
Family	$1,000 per policy year	$2,000 per policy year
Policy Year Deductible Provisions		
Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. See the *Policy year deductibles* provision at the beginning of this schedule for any exceptions to this general rule. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
Family deductible This is the amount you and your covered dependents owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. See the *Policy year deductibles* provision at the beginning of this schedule for any exceptions to this general rule. After the amount you and your covered dependents pay for eligible health services reaches this family policy year deductible, this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the policy year. To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen: • The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year. When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.		
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Physician and specialist services office visits, Consultant services office visits, Walk-in clinic visits, Urgent Care, Outpatient Mental Health & Substance Abuse Treatment Office Visits, Pediatric Vision Care services, and Adult routine vision exams (including refraction) • In-network care and out-of-network care for Emergency ground, air, and water ambulance, Emergency Room, Pediatric Dental Type A services, Well newborn nursery care, and Outpatient prescription drugs		
Maximum out-of-pocket limits		
Student	$7,350 per policy year	$15,000 per policy year
Spouse	$7,350 per policy year	$15,000 per policy year
Each Child	$7,350 per policy year	$15,000 per policy year
Family	$14,700 per policy year	$30,000 per policy year

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Preventive care immunizations		
Performed in a facility or at a physician's office No policy year deductible or copayment applies for children from birth through age 6	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna member website at www.aetnastudenthealth.com or calling the number on the back of your ID card.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		

Eligible health services	In-network coverage	Out-of-network coverage
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. • Pap smear or screening using liquid based cytology methods: 1 Pap smear every 12 months for women age 18 and older. • Gynecological exam that includes a rectovaginal pelvic exam:1 exam every 12 months for women over age 25 who are at risk for ovarian cancer • Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test : 1 exam every 12 months for women age 18 and older. For women over age 60 depending on risk factors.		
Additional maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Use of Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Obesity and/or healthy diet counseling - Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling - Maximum visits per policy year	5 visits	
Use of tobacco products counseling - Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling - Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued)		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums • Mammogram: One mammogram every 12 months for covered persons age 35 and older. When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations. • Prostate specific antigen (PSA) test maximums : One Prostate Specific Antigen (PSA) test every 12 months for covered persons age 50 and older. 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor		
Additional Maximums Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration		
Lung cancer screening maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Family planning services – contraceptives		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – contraceptives (continued)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female Voluntary sterilization - Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
Female Voluntary sterilization - Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine, teledentistry, or telehealth consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Allergy sera and extracts administered via injection		
Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist surgical services (continued)		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays (continued)		
Home health care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	60 visits	
Home health care services do not include custodial care. **The following are not covered under this benefit:** • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Respite care • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	25 days	

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency room	$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card or call Member Services for an address at 1-888-407-0445 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts that are different from the emergency room copayment/coinsurance amounts.		
The following are not covered under this benefit: • Non-emergency services in an emergency room facility or an independent freestanding emergency department or comparable emergency facility		
Urgent care	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19) *The payment or reimbursement for services rendered by a dentist of a non-contracting dental provider shall be reimbursed the same as a contracting dental provider*		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the recognized charge) per visit No copayment or deductible applies
Type B services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the Eligible health services and exclusions section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment

(continued on next page)

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care exclusions (continued) **The following are not covered under this benefit:** • Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits • Pontics, crowns, cast or processed restorations made with high noble metals (gold) • Prescribed drugs, pre-medication or analgesia (nitrous oxide) • Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures • Replacement of teeth beyond the normal complement of 32 • Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits • Services and supplies: - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services - Provided for your personal comfort or convenience or the convenience of another person, including a provider - Provided in connection with treatment or care that is not covered under your policy • Surgical removal of impacted wisdom teeth only for orthodontic reasons • Treatment by other than a dental provider that is legally qualified to furnish dental services or supplies		
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Dental implants		
Oral and maxillofacial treatment (mouth, jaws, and teeth)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Dermatology	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Cosmetic treatment and procedures		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Family planning services – other		
Voluntary sterilization for males - surgical services - Inpatient	80% (of the negotiated charge)	60% (of the recognized charge)
Voluntary sterilization for males - surgical services - Outpatient	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • Abortion except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care		
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not eligible health services under this benefit: • Any treatment, surgery, service or supply that is not in the list above of eligible health services		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Mental Health & Substance Related Disorders Treatment		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Outpatient office visits to a physician or behavioral health provider (includes telemedicine or telehealth consultations)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness			

Eligible health services	In-network coverage	Out-of-network coverage
Infertility Services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Fertility preservation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Infertility services exclusions The following are not covered under the infertility services benefit: • All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services. • Infertility medication • A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person. • Home ovulation prediction kits or home pregnancy tests. • The purchase of donor embryos, donor eggs or donor sperm. • Obtaining sperm from a person not covered under this plan. • Infertility treatment when a successful pregnancy could have been obtained through less costly treatment. • Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. • Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.		
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic follow-up care related to newborn hearing screening	80% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Cardiovascular disease testing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year: 1 screening every 5 years *Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76*		
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Oral anti-cancer prescription drugs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per trip No policy year deductible applies	Paid the same as in-network coverage
Important note: Services received by an out-of-network air ambulance provider will be covered the same as services received by an in-network provider, regardless of emergency status. This includes applying cost shares towards the in-network deductible and out-of-pocket maximum. An out-of-network air ambulance provider cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as deductibles, copayments, and coinsurance, except for those services not covered in your plan.		
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient services		

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above		
Osteoporosis (non-preventive care) Physician's or specialist's office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic Devices Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants		

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered services under this benefit: • Services covered under any other benefit • Repair and replacement due to loss, misuse, abuse or theft		
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies except for complications of diabetes. See the *Diabetic services and supplies (including equipment and training)* section. - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		
Hearing aids and cochlear implants and related services		
Hearing aids and cochlear implants and related services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing aid maximum	One per ear every three years	
Replacement of cochlear implant external speech processor and controller components maximum	One per ear every three years	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 36-month period • Replacement parts or repairs for a hearing aid • Batteries or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist or other provider not acting within the scope of their license		

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids and cochlear implants and related services (continued)		
Hearing exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing exam maximum	1 hearing exam every policy year	
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Pediatric vision care **(Limited to covered persons through the end of the month in which the person turns age 19)**		
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist, optometrist or therapeutic optometrist, or any other providers acting within the scope of their license Includes comprehensive low vision evaluations Includes visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	
***Important note**: Refer to the *Vision care* section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Eligible health services	In-network coverage	Out-of-network coverage
Adult vision care Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist, optometrist or therapeutic optometrist, or any other providers acting within the scope of their license Includes fitting of prescription contact lenses	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Fitting of Contact maximum	1 visit 1 visit	
The following are not covered under this benefit: Adult vision care • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes Adult vision care services and supplies • Special supplies such as non-prescription sunglasses • Special vision procedures, such as orthoptics or vision therapy • Eye exams during your stay in a hospital or other facility for health care • Eyeglasses or duplicate or spare eyeglasses or lenses or frames • Replacement of lenses or frames that are lost or stolen or broken • Acuity tests • Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures • Services to treat errors of refraction		

Outpatient prescription drugs
Outpatient prescription drug copayment waiver for risk reducing breast cancer drugs
The outpatient prescription drug copayment will not apply to risk reducing breast cancer prescription drugs when obtained at an in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.
Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at an in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.

Outpatient prescription drug copayment waiver for contraceptives

The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90 day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Diabetic insulin		
30-day supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
90-day supply at mail order pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Important note: Your cost share will not exceed $25 per 30-day supply of a covered prescription insulin drug filled at an in-network pharmacy. No policy year deductible applies for insulin.		
Important note: When an emergency refill of diabetes supplies is provided, the emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30-day supply or the smallest available package.		
Anti-cancer drugs taken by mouth For each fill up to a 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Preventive care drugs and supplements filled at a retail pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna website at **www.aetnastudenthealth.com** or calling the toll-free number on the back of your ID card.	

Eligible health services	In-network coverage	Out-of-network coverage
Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available		
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

Outpatient prescription drug exclusions

The following are not eligible health services:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy aggravates, causes, or results in a life-threatening physical condition that a physician believes places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless termination of the pregnancy occurs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products, and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance, or increase sexual desire, including drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our preauthorization and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service, or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service

(continued on next page)

Outpatient prescription drug exclusions (continued)

The following are not eligible health services:

- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility, except for drugs used for fertility preservation
- Injectables including:
  - Any charges for the administration or injection of prescription drugs except as described in the Diabetic services and supplies (including equipment and training) section
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

Outpatient prescription drugs important note:

If a provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year deductible or maximum out-of-pocket limit.

Important Note:
When you get prescription drugs from a pharmacy, the pharmacy will only require you at that time to pay the lowest amount of the following:

- The applicable copayment
- The allowable claim amount for the prescription drug
- The amount you would pay for the prescription drug if you bought it without using your plan or any other prescription drug benefits or discounts.

You may later have to pay additional cost sharing for these prescription drugs. For example, if you have not met your prescription drug deductible (if applicable), you may owe additional cost sharing.

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-authorization Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

General Exclusions

Abortion

- Services and supplies provided for an abortion except when the pregnancy aggravates, causes or results in a life-threatening physical condition that a physician believes places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless the abortion is performed

Abortion drugs

- Drugs used for elective termination of pregnancy except when the pregnancy aggravates, causes or results in a life-threatening physical condition that a physician believes places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless termination of the pregnancy occurs

Acupuncture

- Acupuncture
- Acupressure

Behavioral health treatment
- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Blood and blood products
- Blood, blood products, and related services that are supplied to your provider free of charge

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in the *Eligible health services and exclusions* section

Court-ordered testing
- Court-ordered testing or care unless medically necessary

Custodial care
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care except in connection with hospice care, adult or child day care, or convalescent care
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorder treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions

- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants except when part of an approved treatment plan for an eligible health service described in the *Eligible health services and exclusions – Reconstructive surgery and supplies* section.

This exception does not include removal of completely bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Educational services
Examples of these are:
- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations
Any health or dental examinations needed:
- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental, investigational, or unproven
- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Gene-based, cellular, and other innovative therapies

Growth/Height care
- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Jaw joint disorder
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorder treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services and exclusions – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction treatment (CMJ)* section.

Maintenance care
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable
- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Non-U.S. citizen
- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program, except for emergency services

Obesity surgery and services
- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services and exclusions* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer
- Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort, or convenience items
- Any service or supply primarily for your convenience and personal comfort or that of a third party

Private duty nursing outpatient

Routine exams and preventive services and supplies
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services and exclusions* section

School health services
- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy

- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

Services not permitted by law
- Some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member
- Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member, except for when that family member is a dentist who is licensed in the State of Texas to provide the dental service rendered

Sexual dysfunction and enhancement
- Any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Students in mental health field
- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

Telemedicine, teledentistry, or telehealth
- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g., Tele-ICU, Tele-stroke)

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation
- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services and exclusions – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity
- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, unless coverage is required by applicable laws

Voluntary sterilization
- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs
See *Educational services* in this section

Work related illness or injuries
- Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

In case of a medical emergency

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician but only if a delay will not harm your health.

After-hours care — available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in at **www.aetnastudenthealth.com** and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Out-of-area services and benefits

You may not have access to an in-network provider when you are traveling outside of the plan's service area. If you must receive medically necessary services or supplies when traveling outside of the plan's service area, we will reimburse you as shown in the table below.

Type of provider	Your cost share
In-network provider	• You pay the copayment/coinsurance.
Out-of-network provider	• You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment/coinsurance.

Keeping a provider you go to now (continuity of care)

You may have to find a new provider when:

- You join the plan and the provider you have now is not in the network
- You are already covered under another Aetna plan and your provider stops being in our network

But in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

If this situation applies to you, contact us for details. If you are undergoing treatment for an acute or chronic condition and your provider didn't leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your provider for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

	If you have a terminal illness and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the provider terminated their participation with Aetna.
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.
	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.

You will not be responsible for an amount that exceeds the cost share that would have applied had your provider remained in the network.

Complaints and Appeals

If you are dissatisfied with the service you receive from the Plan or you want to complain about a preferred care provider, you may call the Member Services telephone number shown on your ID card or write to Aetna at:
Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. You may submit an appeal if Aetna gives notice of an adverse benefit determination. A final adverse benefit determination notice may also provide an option to request an External Review (if available).

For more information about the Complaints and Appeals Procedure or External Review processes, you may call the Member Services telephone number shown on your ID card. A complete description of the Complaints and Appeals Procedure and External Review processes are contained in the Master Policy/Certificate of Coverage issued to Sam Houston State University and may be viewed online at **www.aetnastudenthealth.com**.

Directory

The list of in-network providers for your plan. The most up-to-date directory for your plan appears at **https://www.aetnastudenthealth.com**. When searching from our online provider directory, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered for certain Aetna plans. When searching for contracting dental providers, you need to make sure you are searching under Pediatric Dental plan.

Upon your request, we will send you a non-electronic version of the directory at no cost to you. Please contact us at (888) 407-0445, or call the Member Services number on the back of your ID card, or write to us at:
Aetna Student Health
151 Farmington Avenue
Hartford, CT 06156

Aetna service areas

The approximate number of students and their dependents insureds in Aetna's service area for Dallas, Austin, Houston and additional areas is 13,992. The numbers of available providers in Aetna's service area for the following provider areas are indicated below:

Service Area	Provider Type: Radiology	Provider Type: Psychiatry	Provider Type: General Practice, Family Practice and Internal Medicine	Provider Type: Specialty-General Surgery	Provider Type: Pediatric PCPs	Provider Type: Specialty	Provider Type: Emergency Medicine
Abernathy						1	
Abilene	3	80	38	9	17	66	3
Addison	1	51	5			5	
Adkins		2				2	
Alamo			3		2	5	
Alamo Heights		3				42	
Albany			3			3	
Aledo		5	4		3	7	
Alfred							
Alice	2	3	5	1	5	11	
Allen	23	351	42	6	15	73	
Alpine			3	2		5	
Alto		1				1	
Alton		4	1			1	
Alvarado		1	1			1	
Alvin		57	7	1	2	10	
Alvord			1			1	
Amarillo	5	118	81	21	21	160	59
Anahuac	2		1			1	
Anderson	1						
Andrews			7	1		9	1
Angleton		34	2	1	2	5	
Anson	1		2	1		3	
Anthony			2			2	
Apple Springs							
Aransas Pass		2	1		2	3	
Anna		3			4	4	
Aquilla							
Argyle		15	3		1	12	8

Arlington	230	381	116	39	30	251	116
Aspermont			1			1	
Atascocita		5	2		3	5	
Atascosa	1	1					
Athens	49	7	19	1	1	29	9
Atlanta	1	5	3			15	12
Aubrey		13	6		2	69	61
Austin	76	3829	435	81	167	1118	775
Austwell			1			1	
Azle	220	7	16	1	1	19	2
Baird		1	1			1	
Bacliff		4				6	
Balch Springs		3	2		1	2	
Balcones Heights		3				3	
Ballinger			2			2	
Bandera		10	7			8	1
Bangs						1	
Bartonville		5	2		1	3	
Bastrop		20	17	3	6	37	17
Bay City	2	5	8	1	4	13	
Baytown	24	58	49	7	16	73	1
Beaumont	60	118	40	18	15	76	6
Bedford	2	74	29	7	7	43	
Bedias							
Bee Cave		40	10			11	1
Beeville	1	3	5	5	7	17	
Bellaire		135	32	13	9	54	
Bellmead		1	5			5	
Bells			1			1	
Bellville	1		3			62	118
Belton		34	20		6	46	20
Benavides			1			1	
Benbrook		47	9			9	
Bertram			1			1	
Big Sandy							
Big Lake							
Big Spring		3	3	1	1	4	
Blue Ridge		1				1	
Big Wells			1			1	
Blanco			1			2	1
Bluff Dale		1				21	

Boerne		44	31	7	10	87	39
Bogata			1			1	
Bonham	1	2	6	1		7	
Booker							
Borger		2	4	3	2	9	
Bowie		4	4	1		5	
Boyd			1			1	
Brady	1	2	3	1		4	
Bracketville			1				
Brazoria		1				21	
Breckenridge	1		2			2	
Bremond			2			2	
Brenham	35	7	18	3	3	38	26
Bridge City			5			7	2
Bridgeport			2			2	
Brookshire		2	1			1	
Brookside Village		1				1	
Brownsboro		2				44	
Brookeland			2			2	
Brownfield			3			3	
Brownsville	8	52	51	19	31	141	76
Brownwood		11	15	4	3	24	2
Bryan	14	83	56	9	4	170	132
Buda		37	10	2	2	34	20
Buffalo			4			4	
Bullard			1			1	
Bulverde		8	4	1	7	12	
Burke		1				1	
Burkburnett			3			3	
Burleson	2	67	26	7	9	138	145
Burnet	9	3	5	2		38	44
Cactus			1			1	
Caddo Mills		1	1			1	
Caldwell	1	2	3			76	144
Cameron		1	3			5	1
Canadian			5			5	
Canton		8	12			47	35
Canutillo			2		2	4	
Canyon		1	7	1		7	
Canyon Lake		4	2			2	
Carrizo Springs	3		2	1	1	7	6

Carrollton	1	168	54	10	15	193	227
Carthage		1	7	1	1	9	
Castle Hills		2				22	
Castroville		1	10		4	15	1
Cedar Creek		1					
Cedar Hill		25	11		3	14	
Cedar Park	123	249	39	9	31	214	237
Celina		3	1		2	2	
Center		1	2			2	
Centerville			2				
Chandler			2			2	
Channelview		1	4			4	
Charlotte		1				1	
Chappell Hill							
Cherokee							
Chico							
Childress			9	1		10	
China							
China Spring		16				5	
Cisco		1				1	
Clarendon			1			1	
Clarksville			3	1		4	1
Claude							
Clean Lake Shores							
Clear Lake Shores		2					
Cibolo		4	1		1	2	
Cleburne	144	14	17	4	2	23	1
Cleveland		8	15	1	5	25	4
Clifton		2	9	1		11	2
Clint					1	1	
Clute		4				9	
Clyde		2	2			2	
Coldspring							
Coleman	1		2			2	
College Station	21	45	61	9	20	194	148
Colleyville		94	22	2	2	31	10
Colorado City			2	1		3	
Columbus	1	1	5	1		7	2
Comanche		2	5			5	
Comfort		1	3			3	
Commerce		4	2			2	

Conroe	6	73	60	13	17	364	295
Converse		36	3	1		3	
Cooper							
Coppell		39	31	3	9	53	10
Copperas Cove		12	7			7	
Corinth		8	5	2	1	8	
Corpus Christi	13	187	106	20	56	279	181
Corsicana	1	24	4	2		5	
Cottonwood Shores		1				1	
Cotulla			2			2	
Crandall		3			1	1	
Crane			2			2	
Crockett			5	1		7	1
Crosby		2	1	1		1	
Crosbyton						1	
Cross Plains		2	2			2	
Cross Roads		10	2			2	
Crowell							
Crowley		8	7			7	
Cumby						1	
Crystal Beach							
Crystal City			1			1	
Cuero		2				21	
Cypress	46	203	71	10	43	230	202
Daingerfield							
Dalhart	2	2	2			4	4
Dallas	383	2164	445	194	138	1221	871
Danbury	1		1				1
Dayton		4	14		2	17	1
Dell City			1			1	
De Kalb			1			2	1
De Leon		1	3			4	1
Decatur	81	18	10	5	3	19	2
Deer Park		8	2		4	6	
De soto			1			1	
Del Rio	14	2	11	8	3	21	1
Del Valle		2	2		1	4	1
Denison	7	21	16	7	5	28	
Denton	94	328	42	42	18	333	270
Denver City	16	1	3	1		5	2
Deport							

DeSoto		32	16	2	8	27	1
Devine		1	3			3	
Diboll		1				7	
Dickinson		7	7		4	11	
Driftwood						1	
Dilley			3	1		4	
Dimmitt			3				
Donna			8		8	16	
Double Oak			1			3	2
Douglass							
Dripping Springs		8	5	1	9	14	
Dublin		1				2	
Dumas	4		7	1		11	5
Duncanville		25	4	2	2	8	
Dyess Afb		1					
Eagle Lake	14	4	2	1		16	27
Eagle Pass	1	3	9	4	3	16	
Early			1			1	
East Bernard			3	1		4	
Eastland			3			3	
Edcouch							
Eden						1	
Edgewood			1		1		
Edinburg	1	101	55	14	33	115	14
Edna	3	3	3	1	1	5	
Egypt							
El Campo	15	1	6	1		9	4
El Paso	125	410	206	61	82	538	364
Eldorado			1			1	
Electra			1			1	
Elgin		2	4		3	7	
Elmendorf						1	
Elkhart			1			2	1
Elsa			5		1	6	
Emory		7	1			1	
Encino						1	
Ennis	1	5	11	1	2	14	
Etoile			1			1	
Euless		41	28		5	39	6
Everman		3				3	
Fabens			2			2	

Fairfield	1		3			3	
Fairview		10				4	
Fair oaks Ranch		1				2	
Falfurrias			3		1	4	
Farmers Branch		28	5	1	1	8	1
Farmersville			2			2	
Flint		2	2			4	2
Fate		3				3	
Ferris			1			1	
Flatonia			2			2	
Flint		2	2			4	2
Floresville	14	7	7	4	1	13	1
Flower Mound	34	183	36	11	11	131	96
Floydada							
Forest Hill			1			1	
Forney		36	5		4	14	5
Fort Davis							
Fort Hancock			1			1	
Fort Hood		1				1	
Fort Sam Houston						1	
Fort Stockton		2	2			2	
Fort Worth	248	749	276	118	91	809	651
Franklin							
Frankston							
Fredericksburg	1	7	31	4	3	41	3
Freeport		7	1			1	
Freer							
Fresno		5				2	
Friendswood		117	16	2	5	26	3
Friona			2			2	
Frisco	134	529	142	20	59	304	101
Fritch		1	1			1	
Ft Worth		2					
Fulshear		38	4		7	11	
Gainesville	2	2	7	2	2	12	2
Galena Park		2			1	1	
Galveston	3	52	10	1		11	
Ganado		1	1			1	
Garden Ridge		17					
Garland		115	53	7	15	198	123
Garrison			1				

Gatesville	6	4	9	1		12	3
George West							
Georgetown	17	150	51	5	20	79	3
Giddings		3	9		2	11	
Gilmer		1	5			5	
Gladewater			3			3	
Glen Rose	10		6	1		7	
Godley			1			2	
Goldthwaite			1			1	
Goliad			1			1	
Gonzales	20		6	1	1	27	36
Goodrich		1				1	
Gordon							
Gorman			1			1	
Graham	15		7	2		9	
Granbury	142	15	22	4	5	65	67
Grand Prairie		74	38		5	79	41
Grand Saline		3	1			1	
Grandview		1	1			1	
Granger							
Grapeland			1			2	1
Grapevine	153	103	18	13	9	234	381
Greenville	3	85	14	2	5	22	1
Groesbeck		2	4			4	
Groves		1	2			3	1
Groveton		2				3	
Gun Barrel City			14			14	
Gunter		1				1	
Hale Center			1			1	
Hallettsville	3		2	3		8	6
Hallsville						1	
Haltom City		1	3			3	
Hamilton		4	4	1		5	
Hamlin							
Harker Heights	77	32	5	4	1	93	151
Harlingen	4	67	51	11	12	169	190
Haskell			1	1		1	
Haslet		11			5	5	
Hawkins		1	2			2	
Hearne			1			1	
Heartland		1					

Heath		21	4		1	6	1
Hebbronville		3	1			1	
Helotes		52	8		4	40	28
Hemphill			1			1	
Hempstead		1	3			3	
Henderson	48	3	7	2	1	9	1
Henrietta	1		4			4	
Hereford		1	5	1	1	7	1
Hermleigh						1	
Hewitt		4	4		1	5	
Hickory Creek		2	1			1	
Highland Park		1				2	
Hico		1	2			2	
Highland Village		12	6		7	13	
Hill Country Village		1				1	
Hidalgo							
Highlands			2			2	
Hillsboro		2	6	2		2	
Hitchcock			1			1	
Hollywood Park		1	5			6	1
Hondo	12	2	7	2		12	3
Honey Grove							
Horizon City	41	2	3		1	5	2
Horseshoe Bay			1			1	
Houston	373	3181	1168	380	441	2650	1236
Howe						1	
Hubbard						1	
Hutchins		1					
Hughes Springs			1			1	
Huffman			1			1	
Humble	8	122	48	11	26	128	79
Hunt		1				1	
Huntington			1		1	1	
Huntsville	1	11	30	1	8	293	254
Hurst	156	18	10	1	6	20	4
Hutto		18	6		4	11	1
Idalou		1					
Ingleside			1		1	2	
Iowa Park			2			2	
Iraan			1			1	
Irving	10	328	88	12	22	379	421

Italy							
Jacksboro			1	1		2	
Jacksonville	6	11	16	4	4	88	121
Jarrell		2					
Jasper	9	3	7	1	3	11	
Jayton			2			2	
Jefferson		1	1			1	
Jersey Village		7	1		1	4	
Joaquin		1				1	
Jones Town						21	
Johnson City			3			3	
Joshua			2			4	
Jourdanton	15		1	1	1	13	22
Junction		3	2			2	
Justin		1	2			2	
Karnes City							
Katy	21	338	116	25	78	267	89
Kaufman	147	20	8	1	2	11	
Keene			2			2	
Keller		116	33	7	9	58	14
Kemah		1				4	
Kemp		2	3			3	
Kempner		3				1	
Kenedy			3	1		4	
Kennedale							
Kermit	1		1			1	
Kerrville	3	20	27	3	1	60	54
Kilgore		4	5		1	53	47
Killeen	68	129	30	6	12	105	107
Kingsland			5			6	1
Kingsville	1	3	7	1	3	11	
Kingwood	22	238	38	10	17	103	38
Kirbyville			2		1	3	
Knox City	1		2			3	1
Kountze			1			1	
Krugerville							
Krum			1			1	
Kyle	1	71	38	6	14	166	212
La Feria			2			2	
La Grange		2	6	2	2	10	
La Joya			2		1	3	

La Marque		2	2			2	
La Mesa							
La Porte		3	4		2	6	
La Vernia		7	7			8	1
Lacy Lakeview			1		1		
Lago Vista			1			1	
Laguna Vista		1	1			1	
Lake Dallas		2				43	
Lake Jackson	4	19	18	2	4	77	106
Lake Worth		3	3		3	6	
Lakehills			1			1	
Lakeway	32	21	15	5	1	85	74
Lamesa			6			7	2
Lampasas	13	3	3		1	17	26
Lancaster		3	4	1		8	6
Lantana						1	
Laredo	7	25	57	12	18	89	3
Lavon							
League City		72	18	1	4	27	4
Leakey		1					
Leander		93	14		6	35	15
Leonard							
Levelland			5	1		6	
Lewisville	1	117	26	4	9	100	122
Lexington						13	13
Liberty		4	6		1	7	
Liberty Hill		8	2		2	4	
Lindale		6	11		1	23	11
Linden						1	1
Little Elm		21	11	1	1	12	
Littlefield	18		1			1	
Live Oak		45	13	8	8	51	44
Livingston		7	16	3	5	24	
Llano			5			19	14
Lockhart		20	8		3	12	1
Lockney			2			2	
Lone Star			1				
Longview	27	80	51	7	17	120	87
Los Fresnos		1			1	1	
Lubbock	61	127	115	37	45	265	124
Lucas					1	1	

Lufkin	3	33	34	3	6	44	1
Luling	47	1	3	1	2	63	113
Lumberton		26	3	1	1	4	
Lyford			1			1	
Lytle		3	3			3	
Mabank		2	2			2	
Madisonville	78		2			72	144
Magnolia		64	10		5	15	
Malakoff			1			1	
Manchaca		5				3	
Manor		5	5		2	7	
Mansfield	92	177	31	12	18	70	15
Manvel		4	1			1	
Marathon							
Marble Falls	45	11	16	3	3	30	16
Marfa			5			5	
Marlin	8	1	5	1		7	2
Marshall	7	8	9	2	2	46	65
Mart		1	1				
Mason		3	1		1	2	
Mc Dade						2	
Mathis			1		2	3	
Maxwell		1					
McCamey			1			1	
Mc Gregor		3	5			5	
Mc Kinney		2				1	
Mc Neil		1				1	
McAllen	1	72	91	24	29	221	142
McKinney	1	526	102	39	36	413	455
Meadow lakes							
Medina		1				2	
Melissa			2		1	3	
Memphis							
Menard		2				2	
Mercedes		1	9		2	11	
Meridian						1	
Merkel		3	2			2	
Mesquite	3	87	41	7	14	67	6
Mexia	3	3	6			6	
Midland	1	30	40	8	17	69	4
Midlothian	2	11	21	4	5	30	

Millsap							
Mineola		7	4			3	
Mineral Wells	1	2	6	2	1	9	
Mission	1	16	41	4	12	61	5
Missouri City		119	30	3	26	67	8
Monahans			1	1		1	
Mont Belvieu		2	2		1	3	1
Montgomery		10	14		2	197	181
Moody							
Morton			1			1	
Moulton							
Mountain Home							
Mt. Enterprise			1			1	
Mt. Pleasant	7	7	9	4	4	19	2
Mt. Vernon		1	1			1	
Muenster	18		3			7	7
Muleshoe	1		1			2	2
Munday			3			3	
Murphy		57	10		7	23	6
N Richland Hls						21	
Nacogdoches	3	23	21	11	5	38	1
Naples			1			1	
Nassau Bay		1			1	2	
Navasota	95	1	11	2		89	151
Nederland		9	7		1	7	
Needville			3			3	
New Boston			2		2	5	1
New Braunfels	7	153	40	9	20	165	110
New Caney		2	4			5	1
Newton			1		1	2	
Nixon							
Nocona	1		3			3	
Normangee							
North Richland Hills	198	86	20	2		58	62
Northlake			3			3	
Odessa	20	17	48	8	13	74	5
Olmito		2	2			2	
Odonnell			1			1	
Olney			3	1		4	
Olton							
Onalaska		1	1			1	

Orange		10	11		2	14	1
Ovalo						21	
Orange Grove							
Ore City							
Overton			1			1	
Ovilla			1			1	
Ozona			1			1	
Paige						1	
Paducah							
Palacios		1	1			1	
Palestine	1	8	15	2	3	22	3
Palmhurst			2			2	
Palmview			1			1	
Pampa		1	5	4		5	
Panhandle			1				
Pantego		18				116	
Paris	1	30	16	4	3	25	2
Parker		2	1			1	
Pasadena	23	77	61	11	31	399	448
Pearland	1	309	81	12	35	440	340
Pearsall		1	8	2		9	
Pecos			5	1		6	
Penitas			1			1	
Perryton			3			3	
Pflugerville		84	23	2	14	145	108
Pharr		6	16		7	26	3
Pinehurst		1	1			1	
Pilot Point		3	1			1	
Pineland							
Pipe Creek		1				21	
Pittsburg		4	5		1	6	
Plains							
Plainview	28	3	12	3	2	15	1
Plano	199	701	205	76	81	637	549
Pleasanton		4	13	1	1	17	2
Port Aransas			1			1	
Port Arthur	4	17	15	2	3	23	3
Port Isabel		1	1			1	
Port Lavaca	11	2	7	1	3	11	
Port Neches		10	2	1	1	4	1
Porter		3	11	1	3	16	1

Portland		5	6		6	12	
Post			1		1	1	
Poteet						1	
Poth		1				21	
Pottsboro							
Premont							
Presidio			3			3	
Princeton		3				2	
Prosper		142	12	3	15	33	9
Providence Village						1	
Quanah			1			1	
Quinlan			2			2	
Quitman	46	2	4	1		5	
Ranger			1				
Rancho Viejo							
Raymondville	1		7		2	10	1
Red Oak		5	8		1	9	
Refugio	1		5			19	28
Rhome		3	1			1	
Richardson	7	256	70	15	21	111	5
Richland Hills		2	4		2	6	
Richmond	17	88	33	3	22	59	1
Rio Grande City	1	10	14	6	5	30	5
Rio Hondo							
Rising Star							
River Oaks		16				15	
Roanoke		9	3			4	1
Robinson		15				32	
Robstown		1	4		1	5	
Roby							
Rockdale		1	2			2	
Rockport		5	3	1	1	4	
Rocksprings			1			1	
Rockwall	1	157	23	9	20	65	18
Rollingwood		4				5	
Roscoe						1	
Roma			2		3	5	
Rosebud		2	3			3	
Rosenberg		50	13	1	2	17	1
Rosharon		2			2	2	
Rotan	1		2			2	

Round Rock	68	436	97	15	51	398	428
Rowlett	161	88	15	3	3	121	194
Royse City		6	6		1	12	5
Rusk		3	3		1	4	
Sabinal			1			1	
Sachse	2	6	4			4	
Saginaw		1	3		1	63	59
Saint Jo			1			1	
Salado			2			2	
San Angelo	10	102	41	8	12	96	64
San Antonio	140	1670	584	195	200	1423	860
San Augustine	2		2			2	
San Benito			10		2	12	
San Diego							
San Elizario			4		3	7	
San Juan		2	8		2	10	
San Marcos	6	48	30	2	11	49	1
San Saba			2			2	
Sanderson			1			1	
Sanger		1	1			1	
Santa Fe		1	1			1	
Santa Rosa		4	3		1	4	
Santo							
Schertz	2	106	13	2	21	42	11
Schulenburg		2	1		1	2	
Scroggins							
Scurry		1					
Seabrook		1	3			3	
Seagoville			1				
Sealy		1	2			2	
Seguin	4	8	22	4	5	192	319
Selma		3				3	
Seminole	1	1	2	3		24	40
Seven Points							
Seymour	4		3	1	1	5	
Shady Shores							
Shallowater			1			1	
Shamrock		1	2			2	
Shavano Park		21	2			2	
Shenandoah		100	88	14	10	140	28
Shepherd		2	1			1	

Sherman	17	45	31	8	9	54	12
Shiner		1	1	1		1	
Shoreacres		1					
Sierra Blanca		1				1	
Silsbee			3			3	
Silverton							
Sinton		1	3		2	5	
Slaton			1			1	
Smithville	2	1	5			99	101
Snyder	19		12	3		20	12
Socorro		2	2		2	4	
Somerset		1	1			1	
Somerville			1				
Smyrna							
Socorro		2	2		2	4	
Sonora			2			2	
South Houston						1	
South Lake		1	1			1	
South Padre Island		1	2			2	
Southlake	148	184	34	7	10	55	4
Spearman			3			3	
Splendora		1	1			1	
Spicewood		8			2	3	
Spring		312	90	5	39	430	296
Spring Branch		31	8	1		10	2
Springtown		2	1			1	
Spur			1			1	
Stafford		51	12		2	15	1
Stamford						2	
Stanton			2				
Stephenville	2	12	11	3	2	18	2
Stinnett			1				
Stockdale			1			1	
Stratford			2				
Streetman			1			1	
St. Hedwig		1					
Sudan							
Sugar Land	34	407	182	35	72	596	551
Sullivan City		1					
Sulphur Springs	17	13	9	2	2	68	105
Sumner		1				1	

Sundown							
Sunnyvale	3	25	5	2	5	13	1
Sutherland Springs		1				1	
Sunset Valley		1	5			5	
Sunray			1			1	
Sweeny	14		6			16	16
Sweetwater		4	5	1	1	6	
Taft		1	1			1	
Tahoka			1			1	
Tatum			2			2	
Taylor	54		12	1		115	201
Teague			5			5	
Telephone							
Temple	66	84	94	42	24	253	180
Tenaha							
Terrell		22	5			6	1
Texarkana	6	23	33	12	9	127	73
Texas City		38	26	2	1	76	47
Texline							
The Colony		35	8			8	
The Hills							
The Woodlands	8	218	59	20	55	460	559
Thorndale			1			1	
Three Rivers		1				3	
Throckmorton			1			1	
Tilden			1			1	
Tioga		1				1	
Timpson							
Tolar		1					
Tomball	23	41	52	6	9	95	48
Trinidad							
Trinity		4	3		1	4	
Trophy Club	3	10	4		2	6	
Troup				1		1	
Tulia	18		2				
Tyler	19	129	92	28	26	231	161
Universal City		61	3			3	
Utopia			1				
University Park						1	
Uvalde	1	2	10	2		12	
Valley View							

Van		1				1	
Van Alstyne		1	3		1	3	
Van Vleck			2			2	
Van Horn							
Vanderpool		1				1	
Venus		8					
Vernon			4	2	1	7	1
Victoria	2	38	40	12	16	77	11
Vidor		1	2			2	
Vinton							
W Lake Hills						3	
Waco	50	105	121	33	24	252	154
Waelder			1			1	
Wake Village						2	2
Waller		1	1		3	4	
Wallis							
Waskom				1		1	
Watauga		16	7			7	
Waxahachie		57	24	8	6	232	194
Weatherford	146	30	18	3	3	40	32
Webster	8	63	59	10	19	142	54
Weimar			3			3	
Wellington			1			1	
Weslaco	9		35	1	9	53	15
West			1			1	
West Columbia			2			2	
West Lake Hills		68	7	1	3	11	
Westworth Village						1	
Wharton		1	6		3	11	2
Whitney		6	4			4	
White Oak						3	
Wheeler			1			1	
White Settlement		11	1			1	
Whitehouse			1			1	
Whitesboro		1	2			2	
Whitewright			1			1	
Whitney		6	4			4	
Wichita Falls	46		35	8	10	56	5
Willis		1	4	2	1	7	
Willow Park		25	8	1	3	13	1
Wills Point		3				4	

Wimberley		7	5		1	6	
Windcrest		2	1			1	
Winnie			1			1	
Winnsboro	149	2	5	1	1	65	113
Winona							
Winters	1		1			1	
Wolfforth			3		1	4	
Woodsboro			1			1	
Woodville	33		2		2	4	1
Woodway		1	2		2	12	3
Wortham			7			1	
Wylie		40	13		11	26	2
Yoakum	4		4			4	1
Yorktown						2	
Zapata		4	2		1	3	
Zavalla							

Important note:
Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit plan unless balance billing for those services is prohibited.

Learn about our network demographics and local market access plans

We annually report health plan data and information to the Texas Department of Insurance (TDI) to assist the TDI in evaluating the adequacy of our networks. If a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, you may view the plan information on our website at **http://www.aetna.com/dse/cms/codeAssets/html/Texas_Network_Adequacy.html**

If you do not have Internet access or prefer a printed copy of the results, contact us at 888-407-0445 or call the Member Services number on the back of your ID card.

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe the network is inadequate, you may file a complaint with the Texas Department of Insurance. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum. You have the right, in most cases, to obtain estimates in advance:

- From out-of-network providers of what they will charge for their services; and
- From your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: **www.aetna.com/docfind** or by calling the number on your Aetna ID card (if you're not yet enrolled, call **1-888-982-3862**) for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits. If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

You can learn more about mediation at the Texas Department of Insurance website: **www.tdi.texas.gov/consumer/cpmmediation.html**.

The Sam Houston State University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-888-407-0445 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: **CRCoordinator@aetna.com**

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

This notice is available at Aetna Inc.'s website: **https://www.aetnastudenthealth.com**

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-888-407-0445** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-407-0445** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-888-407-0445** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-407-0445** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùdù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Bàsɔ̀ɔ̀-wùdù-po-nyɔ̀ jǔ nɨ́, nɨ̀ɨ à wudu kà kò dò po-poɔ̀ bɛ́ m̀ gbo kpáa. Đá **1-888-407-0445** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-888-407-0445** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-407-0445** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-877-407-0445** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-888-407-0445** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-407-0445** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n’efu, dịịrị gị. Kpọọ **1-888-407-0445** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-888-407-0445** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-888-407-0445** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-407-0445** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-877-407-0445** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-407-0445** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-888-407-0445** (TTY: **711**).

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